SECTION I: INSTRUCTIONS TO OFFERORS

1. PROSPECTIVE OFFEROR'S INQUIRIES

Any questions related to this solicitation must be directed to the Solicitation Contact Person listed in Section A. Offerors shall not contact or ask questions of other AHCCCS staff unless authorized by the Contracting Solicitation Contact Person. Questions shall be e-mailed, hand delivered or mailed to the Solicitation Contact Person in the prescribed MS Word format available in the Bidder's Library. In addition, questions hand delivered or mailed must also be submitted on a Compact Disk (CD) and saved in the specified format. The envelope must be marked "RFP Questions- ACUTE CARE". All questions are due to AHCCCS by the dates found in Paragraph 11 of this section. AHCCCS will respond, in writing, to all questions submitted through this process. Written responses will be posted in the Bidder's Library in accordance with the schedule of milestone dates found in Paragraph 11 of this section.

2. PROSPECTIVE OFFEROR'S CONFERENCE AND TECHNICAL INTERFACE MEETING

An Offeror's Conference will be held on February 11, 2008, from 8:30 a.m. until 5:00 p.m., at AHCCCS, 701 E. Jefferson St., Phoenix, Arizona, in the third floor Gold Room. The purpose of this conference will be to: 1) orient new Offerors to AHCCCS, 2) clarify the contents of this solicitation, and 3) clarify the AHCCCS PMMIS System and interface requirements. Any doubt as to the contents and requirements of this solicitation or any apparent omission or discrepancy should be presented at this conference. Questions posed during the Prospective Offeror's Conference must also be submitted as specified in Paragraph 1 of this section. Verbal responses provided during the Conference are not binding.

3. PROPOSAL OPENING

Proposals will be opened publicly immediately following the proposal due date and time. The name of each Offeror will be read aloud and recorded, but no other information contained in the proposals will be disclosed. Proposals will not be available for public inspection until after contract award.

4. LATE PROPOSALS

Late proposals will not be considered.

5. WITHDRAWAL OF PROPOSAL

At any time prior to the proposal due date and time, the Offeror (or designated representative) may withdraw its proposal. Withdrawals must be provided in writing and submitted to the Solicitation Contact Person listed in Section A.

6. AMENDMENTS TO RFP

Amendments may be issued subsequent to the issue date of this solicitation. Receipt of solicitation amendments must be acknowledged by signing and returning the signature pages of each amendment with the proposal submission to the Solicitation Contact Person listed in Section A**.** Receipt of solicitation amendment #3, which will contain the response to submission requirements 12 (Capitation), 72 (Organization), and 73 (Organization), should be acknowledged by signing and returning the signature page on April 18th with the response to these requirements and a copy of Attachment J(2) of this document "Checklist for April 18th Submission".

7. ON-SITE REVIEW

Prior to or as part of a contract award, all Offerors may be subject to on-site review(s) to determine that an infrastructure is in place that will support the provision of services to the Acute population within the GSAs bid.

8. BEST AND FINAL OFFERS

AHCCCS reserves the right to accept any or all initial offers without further negotiation and may choose not to request a best and final offer (BFO). Offerors are therefore advised to submit their most competitive offers at the outset. However, if it is considered in the best interest of the State, AHCCCS may issue a written request to submit a BFO in a particular GSA. The purpose of a BFO request is to allow Offerors an opportunity to resubmit bids for rates not previously accepted by AHCCCS. This request will notify the Offeror of the date, time and place for the resubmission of the capitation rate bid. In addition, AHCCCS will disclose to each Offeror which of its bid rates are acceptable (within or below actuarial rate range), and which are not acceptable (above the actuarial rate range). Final bid rates that fall below the bottom of the actuarial rate range will be increased to the bottom of that rate range after the final BFO. If an Offeror does not submit a notice of withdrawal or participate in a requested BFO, its immediate previous offer will be considered its best and final offer.

All BFOs must be submitted via the AHCCCS website. AHCCCS will limit the number of BFO rounds if it is in the best interest of the State. Offerors will be permitted, within the restrictions and limitations defined below, to adjust a capitation rate upward for a risk group that was previously accepted to offset the reduction of a capitation rate in another risk group in the first BFO round only. These restrictions and limitations include, but are not limited to:

a. An Offeror will be allowed to adjust upward a previously accepted rate only during the first BFO round;

b. The weighted amount of BFO increase cannot exceed the weighted amount of BFO reduction. AHCCCS will furnish the Offeror, in the Data Supplement, the enrollment percentages, by risk group, by GSA, to be used in determining the weighted amount. Should the weighted amount of the adjustment exceed the weighted amount of the BFO reduction, AHCCCS shall reject the first BFO and the adjustment (costing the Offeror the loss of the first BFO round in that GSA). Since a risk group can only be adjusted during the first BFO round, the Offeror will lose the opportunity to make an upward capitation adjustment to previously accepted risk group bids in that GSA.

   For example, assume that SSI w/o Medicare was the risk group where a BFO was needed and the Offeror reduced this rate by $10 PMPM. Also assume the SSI w/o Medicare risk group accounted for 9% of the members in the GSA.

   Weighted Average Capitation Reduction - 9% X $10.00 = $.90

   Assume the risk group adjusted upward was TANF and this risk group was increased by $2.00 PMPM. Also assume this risk group accounted for 50% of the members in the GSA.

   Weighted Average Capitation Increase - 50% X $2.00 = $1.00

   Therefore, the BFO would be rejected because the weighted amount of the BFO upward adjustment exceeded the weighted amount of the BFO reduction.

c. Offerors will not be allowed to decrease a bid in a BFO round if the initial bid was below the bottom of the rate range. If such a BFO is submitted it will be rejected.

d. If an adjustment during the initial BFO round causes the Offeror to exceed the upper range of any risk group, AHCCCS will reject the adjustment and return the (adjusted) risk group to the initial capitation rate bid by the Offeror. Since a previously accepted risk group bid can only be adjusted during the first BFO round, the Offeror will lose the opportunity to make an upward capitation adjustment for this risk group.

e. AHCCCS reserves the sole right to accept or reject any adjustment. By submitting an adjustment to a risk group, the Offeror is requesting approval by AHCCCS; such approval shall not be automatic. If an initial bid is below the bottom of a rate range, it cannot be adjusted downward by the Offeror in a BFO round.

Capitation Rates Offered after the BFOs: As stated above, AHCCCS may limit the number of BFO rounds. After the final BFO round is complete, provided it is in the best interest of the State, AHCCCS will cease issuing BFO requests. At this point, should the Offeror have a risk group without an accepted capitation rate, AHCCCS shall offer a capitation rate to the Offeror. The capitation rate offered should be somewhere in the bottom half of the rate range (specific placement to be determined by AHCCCS and its actuaries). Note that all rates offered in this manner shall be identical for all offerors in the same GSA and risk group.

9. AWARD OF CONTRACT

AHCCCS has determined that the provision of covered services to eligible populations in the GSAs as described below will stabilize risk sharing. The Offeror must therefore bid on at least one entire GSA in order to be considered for a contract award. Although AHCCCS encourages Offerors to bid on multiple GSAs, AHCCCS may limit the number of GSAs awarded to any one Offeror, if deemed in the best interest of the State.

Notwithstanding any other provision of this solicitation, AHCCCS expressly reserves the right to:

a. Waive any immaterial mistake or informality;
b. Reject any or all proposals, or portions thereof; and/or
c. Reissue a Request for Proposal

AHCCCS will not make an award in a single GSA to any single organization that owns or manages more than one contract, or to two Contractors that utilize the same management service company.

If there are significant compliance issues with a current Contractor, or a Contractor's contract in a particular GSA has been previously terminated, AHCCCS retains the right to address that compliance or termination issue on an individual basis, according to what is deemed in the best interest of the State. A new bid proposal may not be accepted until it has been determined that the reason for the significant compliance or termination issue has been resolved and there is a reasonable assurance that it will not recur.

If there are significant compliance issues with a new Offeror's performance in another state or with another governmental entity, AHCCCS retains the right to address that compliance or termination issue on an individual basis according to what is deemed in the best interest of the State.

Subsequent to the award of contracts, in the event of significant non-compliance issues with a Contractor in a particular GSA, AHCCCS may refer back to the results of the evaluation of this solicitation and select another Contractor for a particular GSA that is considered to be in the best interest of the State.

A response to this Request for Proposals is an offer to contract with AHCCCS based upon the terms, conditions, scope of work and specifications of the RFP. All of the terms and conditions of the contract are contained in this solicitation, solicitation amendments and subsequent contract amendments, if any, signed by the Contracting Officer. Proposals do not become contracts unless and until they are accepted by the Contracting Officer. The proposal provided by the Offeror will become part of the contract with AHCCCS. A contract is formed when the AHCCCS Contracting Officer signs the award page and provides written notice of the award(s) to the successful Offeror(s), and the Offeror accepts any special provisions to the contract and the final rates awarded. AHCCCS may also, at its sole option, modify any requirements described herein. All Offerors will be promptly notified of award.

AHCCCS reserves the right to specify and/or modify the number of contracts to be awarded in any GSA. AHCCCS anticipates awarding contracts as follows:

GSA #:	*County or Counties*	*Number of Awards:*
2	Yuma, La Paz	Maximum of 2
4	Apache, Coconino, Mohave, and Navajo	Maximum of 2
6	Yavapai	Maximum of 2

8	Gila, Pinal	Maximum of 2
10	Pima, Santa Cruz*	Maximum of 5
12	Maricopa	Maximum of 6
14	Graham, Greenlee, Cochise	Maximum of 2

Note: *AHCCCS anticipates awarding up to five contracts in the Pima County portion of the Pima/Santa Cruz GSA. Contracts will be awarded in Santa Cruz County to only two of the five Pima contract awardees.

An existing contractor in Maricopa or Pima County who is not awarded a CYE 09 contract may request to have its enrollment capped and to continue providing services under the terms and conditions of this new Contract. AHCCCS may, at its sole option, grant or deny such a request. If AHCCCS approves such an enrollment cap, the Contractor would continue to serve its existing members but would not receive any new members and their membership will not be included in the Conversion Group described below. The enrollment cap will not be lifted during the term of this or any subsequent contract period unless one of the following conditions exists:

a. Another contractor is terminated and increased member capacity is needed, or
b. Legislative action creates a sudden and substantial increase in the overall AHCCCS population, or
c. Extraordinary and unforeseen circumstances make such an action necessary and in the best interest of the State.

If an existing contractor is not awarded a new or capped (as mentioned above) contract, AHCCCS will assign the membership as follows:

Conversion Group
On June 30, 2008, AHCCCS will identify all members that are currently enrolled in a plan that is exiting any GSA effective September 30, 2008, and will classify those members as the Conversion Group. The Conversion Group members will be auto-assigned to select Contractors as described in Attachment G *Auto-Assignment Algorithm*.

On July 1, 2008, the Conversion Group will be mailed a letter indicating that the Contractor with which they are currently enrolled will no longer be available, and will be provided with the name of the Contractor that they will be assigned to as of October 1, 2008. From July, 1, 2008, to August 31, 2008, and again from October 1, 2008 to November 30, 2008, the Conversion Group will be provided with an opportunity to change plans by selecting from the Contractors that have been awarded CYE09 contracts in their GSA.

AHCCCS will provide all Contractors with a potential membership files on July 1, 2008 that contains the Conversion Group Contractor assignments that will be effective October 1, 2008 as well as any regular Annual Enrollment Choice plan changes. Contractors will receive additional membership files on or about August 15, September 1, and September 15, 2008. These additional files will identify the members that have elected to change Contractors.

Beginning on September 2, 2008, Relinquishing Contractors (Contractors who are exiting a GSA) will provide electronic files containing member transition information, in the format established by AHCCCS, to the Receiving Contractors (those Contractors to which Conversion Group members are assigned). This information exchange must be completed by September 5, 2008.

Based on the importance of continuity of care during the transition period, the Receiving Contractor is expected to honor the Relinquishing Contractor's previously issued prior authorizations or waive its own prior authorization requirements for any previously scheduled outpatient services and/or prescribed pharmaceuticals until November 30, 2008. The Contractor is also expected to waive any requirement for Conversion Group members to use the Contractor's provider network until October 31, 2008. The Receiving Contractor should apply medical necessity criteria when paying for services. The Contractor will receive an official enrollment file for October enrollment prior to October 1, 2008. Receiving Contractors are expected to secure an appropriate network for the membership identified in the transition files in order to address any potential service gaps by November 30, 2008. Receiving

Contractors must attempt to contract with Primary Care Physicians historically utilized by the transitioning members for both continuity of care and to maintain its membership.

New Members after Contract Awards
Members who become eligible and enrolled between May 1, 2008 and July 31, 2008 will have the opportunity to choose from all of the Contractors currently contracted with AHCCCS. AHCCCS will continue to auto assign members to all Contractors currently contracted with AHCCCS until July 31, 2008. Starting August 1, 2008, new members will only be offered choice of Continuing Contractors (currently an AHCCCS Contractor in the GSA and awarded a CYE 09 Contract). Members who do not make a choice will be auto assigned to a Continuing Contractor.

If none of the current Contractors in a GSA are awarded a CYE09 contract, members will have the ability to choose Contractors in their GSA that are currently contracted with AHCCCS in that GSA. Members that do not make a choice will be auto assigned to one of the Contractors in their GSA that are currently contracted with AHCCCS in that GSA.

Members who have chosen or have been assigned to an Exiting Contractor (a Contractor not awarded a CYE 09 contract) between May 1, 2008 and June 30, 2008 will be included in the Conversion Group, assigned to a new Contractor, and their transition must be managed as indicated in the Conversion Group section.

Members who have chosen or have been assigned to an Exiting Contractor after June 30, 2008, through and including July 31, 2008 will be auto assigned by the process described in Attachment G *Auto-Assignment Algorithm* and included in the October official enrollment file.

Although choice of an Exiting Contractor ends July 31, 2008, there are limited instances (family continuity, newborn enrollment or 90-day re-enrollment) when assignment to an Exiting Contractor will occur through September 30, 2008. Members assigned under these circumstances will be moved via the process described in Attachment G *Auto-Assignment Algorithm* and included in the October official enrollment file.

All of the members who became eligible and enrolled after contracts have been awarded but before October 1, 2008, that are not transitioned into the Conversion Group, will also be provided with the opportunity to select any of the Contractors available in their GSA from October 1, 2008 to November 30, 2008. The Contractor is encouraged to execute contracts with the providers utilized by the transitioning members, in an attempt to maintain its membership.

Annual Enrollment Choice
AHCCCS will suspend Annual Enrollment Choice for all members who would have been notified of their AEC opportunity for the months of May, June and July 2008. The affected members will be afforded an opportunity to choose from the Contractors awarded CYE09 contracts in their GSA starting in August, 2008 for an October 1, 2008 effective date.

10. FEDERAL DEADLINE FOR SIGNING CONTRACT

The Center for Medicare and Medicaid Services (CMS) has imposed strict deadlines for finalization of contracts in order to qualify for federal financial participation. This contract, and all subsequent amendments, must be completed and signed by both parties, and must be available for submission to CMS prior to the beginning date for the contract term (October 1, 2008). All public entity Offerors must ensure that the approval of this contract is placed on appropriate agendas well in advance to ensure compliance with this deadline. Any withholding of federal funds caused by the Offeror's failure to comply with this requirement shall be borne in full by the Offeror.

11. RFP MILESTONE DATES

The following is the schedule of events regarding the solicitation process. These dates are subject to change based on the best interest of the State:

Activity	Date
RFP Issued	February 1, 2008
Prospective Offerors Conference and Technical Assistance Session	February 11, 2008 - AM
Information Technology (IT) PMMIS Technical Interface Meeting	February 11, 2008 - PM
Technical Assistance and RFP Questions Due by 5:00 P.M. MST	February 15, 2008
RFP Amendment, if necessary, and Formal Response to Questions	February 29, 2008
Second Set of Technical Assistance and RFP Questions Due by 5:00 P.M. MST	March 7, 2008
Second RFP Amendment Issued, if necessary, and Formal Response to Second Set of Questions	March 14, 2008
Proposals Due by 3:00 P.M. MST*	March 28, 2008
Reponses to Submission Requirements 12, 72, and 73 by 3:00 P.M. MST*	April 18, 2008
Contracts Awarded	No later than May 23, 2008
Readiness Reviews Begin	July 1, 2008
New Contracts Effective	October 1, 2008

*The due date for Submission Requirements numbered 12 (Capitation), 72 (Organization) and 73 (Organization), will be April 18th at 3:00 pm. No late submissions will be accepted. Any submission of responses to these requirements that is received as part of the March 28th submission will be treated as confidential and not scored. Offerors may reclaim these submissions from the Contract Solicitation Person listed in Section A.

Offerors are encouraged to continue to check the Open RFPs section of the AHCCCS website for any changes.

12. AHCCCS BIDDER'S LIBRARY

The Bidder's Library contains critical reference material including, but not limited to, AHCCCS policies; utilization; member data; and performance requirements to assist the Offeror in preparing a thorough and realistic response to this solicitation. References are made throughout this solicitation to material in the Bidder's Library and on the AHCCCS website. Offerors are responsible for reviewing the contents of the Bidder's Library material as if they were printed in full herein. All such material is incorporated into the contract by reference. The Bidder's Library is located on the AHCCCS website at http://www.azahcccs.gov/Contracting/BidderLib.asp

13. OFFEROR'S INABILITY TO MEET REQUIREMENTS

If a potential offeror cannot meet the minimum capitalization requirements, the performance bond requirements, or the minimum network standards described herein, AHCCCS requests that the potential offeror not submit a bid.

Minimum Capitalization Requirements:

The Offeror must meet a minimum capitalization requirement for each GSA bid in order for the bid to be scored. The capitalization requirement must be met within 30 days after contract award.

Minimum capitalization requirements by GSA are as follows:

Geographic Service Area (GSA)	Capitalization Requirement
Mohave/Coconino/Apache/Navajo	$4,400,000
La Paz/Yuma	$3,000,000
Maricopa	$5,000,000
Pima/Santa Cruz	$4,500,000
Cochise/Graham/ Greenlee	$2,150,000
Pinal/Gila	$2,400,000
Yavapai	$1,600,000

New Offerors (any Offeror that is not currently an Acute Care Contractor with AHCCCS)*:* To be considered for a contract award in a given GSA or group of GSAs, a new Offeror must meet the minimum capitalization requirements listed above. The capitalization requirement is subject to a $10,000,000 ceiling regardless of the number of GSAs awarded. This requirement is in addition to the Performance Bond requirements defined in Section D, Paragraphs 46, Performance Bond or Bond Substitute, and 47, Amount of Performance Bond, and must be met with cash with no encumbrances, such as a loan subject to repayment. The capitalization requirement may be applied toward meeting the equity per member requirement (see Section D, Paragraph 50, Financial Viability Standards) and is intended for use in operations of the Contractor.

Continuing Offerors: Continuing Offerors that are bidding a county or GSA in which they currently have a contract must meet the equity per member standard (see Section D, Paragraph 50, Financial Viability Standards) for their current membership. Continuing Offerors that do not meet the equity standard must fund, through capital contribution, the necessary amount to meet the minimum capitalization requirement. Continuing Offerors that are bidding a new GSA must provide the additional capitalization for the new GSA they are bidding. The amount of the required capitalization for continuing Offerors may differ from that for new Offerors due to size of the continuing Offeror's current enrollment. Continuing Offerors will not be required to provide additional capitalization for new GSAs if they currently meet the equity per member standard with their existing membership and their excess equity is sufficient to cover the proposed additional members, or they have at least $10,000,000 in equity.

14. CONTENTS OF OFFEROR'S PROPOSAL

All proposals (original and seven copies) shall be organized with strict adherence to the Offeror's Checklist (Attachment J) as described in this section and submitted using the forms and specifications provided in this RFP. All pages of the Offeror's proposal must be numbered sequentially with documents placed in sturdy 3-inch, 3-ring binders. All responses shall be in 11 point font or larger with borders no less than ½". Unless otherwise specified, responses to each submission requirement must be limited to three (3) 8½" x 11" one sided, single spaced, type written pages. Erasures, interlineations or other modifications in the proposal must be initialed in original ink by the authorized person signing the offer. A policy, brochure, or reference to a policy or manual does not constitute an adequate response. AHCCCS will not reimburse the Offeror the cost of proposal preparation.

It is the responsibility of the Offeror to examine the entire RFP, seek clarification of any requirement that may not be clear, and check all responses for accuracy before submitting its proposal. The proposal becomes a part of the contract; thus, what is stated in the proposal may be evaluated either during the proposal evaluation process or during other reviews. Proposals may not be withdrawn after the published due date and time.

All proposals will become the property of AHCCCS. The Offeror may designate certain information to be proprietary in nature by typing the word "proprietary" on top of every page for which nondisclosure is requested. Final determinations of nondisclosure, however, rest with the AHCCCS Director. Regardless of such determinations, all portions of the Offeror's proposal, even pages that are proprietary, will be provided to CMS.

All proposals shall be organized according to the following major categories:

I. General Matters
II. Network
III. Capitation
IV. Program
V. Organization
VI. Other

Each section shall be separated by a divider and contain all information requested in this solicitation. Numbering of pages should continue in sequence through each separate section. For example, " Network" would begin with the page number following the last page number in "General Matters". Each section shall begin with a table of contents.

Proposals that are not submitted in conformance with the guidelines described herein will not be considered. References to various sections of the RFP document in Section I are intended to be of assistance and are not intended to represent all requirements. Other possible resources may be found in the Bidder's Library.

All responses incorporating examples of past performance and/or outcome data must comply with the following requirements:

- Incumbents must submit based on their AHCCCS Acute line of business
- New Offerors currently operating as Managed Care Organizations (MCO), must submit all historical information from the same MCO/line of business

The following specifies the submission requirements.

I. General Matters

See the Offeror's Checklist (Attachment J) for information to be submitted under this section.

II. Network

The Offeror shall have in place an adequate network of providers capable of meeting contract requirements. Attachment B lists minimum geographic network requirements by GSA. The following specifies the submission requirements.

Required Submissions: Network

Network Questions

1. The Offeror must provide the:

    a. Network Attestation Statement and attachments, located in the Bidder's Library, listing the number of providers by provider type in each community listed within for each GSA bid.

    b. The Offeror must also submit 3 CDs containing the Offeror's complete network by GSA on the CYE '09 RFP Minimum Network Standards Excel Spreadsheet located in the Bidder's Library.

    References: Section D, Paragraph 27, Attachment B; Network Attestation Statement; Minimum Network Standards Excel Spreadsheet; Minimum Network Standards Instructions

2. The Offeror must submit a Network Development and Management plan. The submission may exceed the three (3) page maximum.
    References: Section D, Paragraphs 27, Network Development, and 29, Network Management; ACOM 415, Provider Network Development and Management Plan Policy

3. Any Offeror that is new to a GSA or is a Continuing Offeror with less than 50,000 members in the Maricopa GSA, or 30,000 members in Pima County, or less than 50% of the members in a rural GSA, must submit a description of how it will launch a network capable of supporting this minimum membership by October 1, 2008. (Current Contractors that are not bidding on a new GSA and have a membership higher than those listed above in the GSAs in which they are currently operating, will not be evaluated on this Submission Requirement)
   References: Section D, Paragraph 6, Auto Assignment Algorithm, 27, Network Development, and 29, Network Management; ACOM 415, Provider Network Development and Management Plan Policy, and 416, Provider Information Policy

4. Describe the methodologies and interventions used by the Offeror that are considered to be innovative and proactive for reducing unnecessary ER utilization. Include the reason(s) why these are felt to be innovative and proactive.
   References: Section D, Paragraph 27, Network Development; ACOM 415, Provider Network Information Policy; AMPM Chapter 400.

5. Describe the contents of the initial PCP training offered to providers that are new to the network.
   References: Section D, Paragraph 29, Network Management; ACOM 416, Provider Information Policy; AMPM Chapter 400

6. Describe how the organization will communicate with its provider network regarding program standards, changes in laws and regulations and changes in subcontract requirements.
   References: Section D, Paragraph, 29, Network Management; ACOM 416, Provider Information Policy

7. Describe the process for accepting and managing provider inquiries, complaints, and requests for information that are received outside of the Claim Dispute process.
   References: Section D, Paragraph 29, Network Management

8. Describe how the results obtained through various types of provider and network monitoring (i.e., Provider Relations, Quality Management, Case Management, Grievance System, Medical Management etc.) are used to manage and improve the network. Identify how provider issues are communicated within the organization.
   References: Section D, Paragraph 27, Network Development, and 29, Network Management; ACOM 415, Provider Network Development and Management Plan Policy

9. Describe how the organization will monitor the potential for and handle the loss (i.e., contract termination, closure or natural disaster) in a GSA of a) hospital/hospital system and/or b) a large provider group. The response must address how the Offeror will ensure that members receive medically necessary services if such a situation occurs.
   References: Section D, Paragraphs 27, Network Development, and 29, Network Management; ACOM 104, Business Continuity and Recovery Plan

10. Describe how feedback (turnover, complaints, survey results etc.) from the contracted network is used to drive changes and/or improvements to the Offeror's Operations.
    References: Section D, Paragraphs 19, Surveys, 27, Network Development, and 29, Network Management;

11. Describe the process to identify and reduce the member no-show rate for appointments across the spectrum of care (e.g. oral heath, physician, transportation, Children's Rehabilitative Services, etc.). Describe no-show identification methods, interventions, best practices, member and provider outreach approaches, and how outcomes of the processes implemented to reduce the no-show rate are or will be evaluated for effectiveness. Submission requirement can be a maximum of five (5) pages.
    References: Section D, Paragraph 33, Appointment Standards; ACOM 417, Appointment Availability Monitoring and Reporting Policy

III. Capitation

Capitation is a fixed (per-member) monthly payment to a Contractor for the provision of covered services to members. It is an actuarially sound amount to cover expected utilization and costs for the individual risk groups in a risk-sharing, managed care environment. The Offeror must demonstrate that the capitation rates proposed are actuarially sound. In general terms, this means that the Offeror that is awarded a contract should be able to keep utilization at or near its proposed levels and should be able to contract for unit costs that average at or near the amounts shown on the CCFR. This requirement also applies to bids submitted in best and final offer rounds.

Prior Period Coverage (PPC), MED Prospective, Delivery Supplement, SOBRA Family Planning, SSDI-TMC and State Only Transplant rates will be set by the AHCCCS actuaries and not bid by the Contractor. See Section D, Paragraph 53, Compensation, for information regarding risk sharing for the PPC time period, MED Prospective members and the SSDI-TMC members. All other risk groups will be subject to competitive bidding.

To facilitate the preparation of capitation proposals, a Data Supplement is provided in the Bidder's Library. This data source should not be used as the sole source of information in making decisions concerning the capitation proposal. Each Offeror is solely responsible for research, preparation and documentation of its capitation proposal.

Required Submission: Capitation

Capitation

12. Submit a capitation proposal using the AHCCCS bid web tool. Instructions for accessing and using the web tool will be issued on or about February 15, 2008. The Offeror must have an actuary who is a member of the American Academy of Actuaries certify that the bid submission is actuarially sound. This certification is also required with subsequent submissions in Best and Final Offer rounds (if applicable). The Offeror must also submit hard copy print outs of the web tool. Refer to Attachment E for more details.

    The Offeror should assume that all AHCCCS-covered medical services are included in the capitation rates. Bidders are to bid rates by GSA and risk category reflecting the expected average monthly cost of an enrollee who has average demographic and health status using the data provided by AHCCCS in the Bidder's Library. Bidders should not take into account their own unique membership demographic or diagnosis experience, but can factor in the anticipated impact of the Contractor's unique medical management and/or unit cost experience.

    The Offeror must prepare and submit its capitation proposal assuming a $20,000 deductible level for regular reinsurance, for all risk groups, in all GSAs. AHCCCS will provide the reinsurance offset amounts via the bid web tool and Section N of the data supplement for each risk group, for each GSA. Prior to the contract award AHCCCS will provide a table of per-member per-month reinsurance adjustments to be made to capitation rates for the Contractor whose actual deductible level exceeds $20,000.

IV. Program

Required Submissions: Program

Program Questions

13. Describe how the Offeror identifies quality improvement opportunities. Describe the process to select a performance improvement project, and the process to develop multi-departmental interventions to improve care or services. Describe the process for evaluating the effectiveness of the interventions. In addition to the three-page submission the Offeror must include a two-page sample Performance Improvement methodology for a relevant topic.
    References: Section D, Paragraph 23, Quality Management (QM); AMPM, Chapter 900

14. Describe how the results of the Offeror's monitoring and evaluation of overall performance is incorporated into the Quality Management/Quality Improvement Program structure.
References: Section D, Paragraph 23, Quality Management (QM); AMPM, Chapter 900

15. Describe how peer review is utilized by Offeror and incorporated into quality management processes.
References: Section D, Paragraph 23, Quality Management (QM); AMPM, Chapter 900

16. Describe how quality of care and service complaints are identified, researched, resolved and the resolution will be communicated to the member.
References: Section D, Paragraph 23, Quality Management (QM); AMPM, Chapter 900

17. Describe the qualifications of the staff that will perform the quality management and quality improvement functions for the Offeror. Note if these persons are solely responsible for quality management functions.
References: Section D, Paragraph 16, Staff Requirements and Support Services; AMPM, Chapter 900

18. Describe the process for provisional credentialing, initial credentialing, recredentialing and organizational credentialing for all provider types specified in the AMPM. Please include a description of the Quality Management Unit and the Medical Director's role in the Offeror's process.
References: Section D, Paragraph 23, Quality Management (QM); AMPM, Chapter 900

19. Describe the process utilized to train Offeror's staff, other than Quality Management staff, regarding identification and appropriate referral of quality of care concerns.
References: Section D, Paragraph 23, Quality Management (QM); AMPM, Chapter 900

20. Describe the process utilized to coordinate care or provide additional assistance to members identified as having difficulties with accessing care. Include processes for assisting challenging members identified through the quality of care process and those members that may be referred by AHCCCS.
References: Section D, Paragraphs 23, Quality Management (QM), and 24, Medical Management; AMPM, Chapters 400, 900, and 1000

21. Describe the Offeror's experience and commitment to improving quality of care and performance in specific measures of health care services, and how this commitment is spread throughout the organization.
References: Section D, Paragraph 23, Quality Management (QM); AMPM, Chapter 900.

22. Provide results/rates for any HEDIS or HEDIS-like measure from a state in which the Offeror participates in the Medicaid line of business and in which the Offeror has experienced sustained, statistically significant improvement within the last three years. Include a minimum of three years of results, including numerators and denominators for the measure and statistical significance of change (e.g. chi-square test).
References: Section D, Paragraph 23, Quality Management (QM); AMPM, Chapter 900.

23. Describe how the Offeror gathers and analyzes utilization data. In addition to no more than three pages of narrative, the Offeror must include three pages of example utilization reports.
References: Section D, Paragraph 24, Medical Management (MM); AMPM, Chapter 1000

24. Provide an example of when the Offeror's analysis of data resulted in changes to medical management programs.
References: Section D, Paragraph 24, Medical Management (MM); AMPM, Chapter 1000

25. Describe the Offeror's existing or planned disease/chronic care management programs that are designed to improve care for members with one or more chronic illnesses.
References: Section D, Paragraph 24, Medical Management (MM); AMPM, Chapter 1000

26. Describe the staff and processes utilized by the Offeror to conduct concurrent and retrospective review of hospital stays.
References: Section D, Paragraph 24, Medical Management (MM); AMPM, Chapter 1000

27. Describe the staff and processes utilized by the Offeror to review requests for prior authorization.
References: Section D, Paragraph 24, Medical Management (MM); AMPM, Chapter 1000

28. Describe existing or planned relationships with Medicare plans (MA, MAPDP or PDP) that will allow for coordination of care between Medicare and Medicaid services.
References: Section D, Paragraphs 10, Scope of Services, and 60, Medicare Services and Cost Sharing; Section H, Evaluation Factors and Selection Process

29. Describe how the Offeror identifies members needing assistance navigating the health care delivery system. Describe what assistance is provided, and how the effectiveness of the assistance is evaluated.
References: Section D, Paragraphs 11, Special Health Care Needs, 23, Quality Management (QM), and 24, Medical Management (MM); AMPM, Chapters 900 and 1000

30. Describe planned health promotion, outreach, and monitoring of adult preventive/early detection services including well woman, well man, adult immunizations and chronic disease.
References: Section D, Paragraph 10, Scope of Services; AMPM, Chapters 400, 900 and 1000

31. Describe planned health promotion, outreach, and monitoring for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) and explain how the EPSDT program is integrated within the organization. Describe how EPSDT Tracking Forms are utilized to identify specific member needs such as AzEIP referral, PEDS tool, behavioral health, oral health, and CRS conditions.
References: Section D, Paragraph 10, Scope of Services - EPSDT; AMPM, Chapters 400 and 900

32. Describe planned outreach and care coordination processes for populations of children with special health care needs and other hard-to-reach populations such as those identified through the use of the PEDS tool and eligible or enrolled in the AzEIP, CRS and/or a Regional Behavioral Health Authority (RBHA).
References: Section D, Paragraph 11, Special Health Care Needs; AMPM, Chapters 400 and 900

33. Describe planned health promotion, outreach, and monitoring strategies for maternity care, including post partum care. Include a description of how care will be coordinated for physical and behavioral care needs. Describe process to increase provider participation in Baby Arizona.
References: Section D, Paragraphs 10, Scope of Services, and 30, Primary Care Provider Standards; AMPM, Chapters 400, 900 and 1000

34. Describe how intervention activities to improve access to adult preventive health/early detection, EPSDT and maternity care will be evaluated for effectiveness. Describe what the Offeror will do if interventions are not effective.
References: Section D, Paragraph 23, Quality Management (QM); AMPM, Chapters 400 and 900

35. Describe the Offeror's EPSDT and Maternal (MCH) organizational structure. Describe the staff functions within the organizational structure to ensure care needs are met. The Offeror must note if staff persons are dedicated solely to EPSDT and/or MCH functions.
References: Section D, Paragraph 16, Staff Requirements and Support Services; AMPM, Chapters 400 and 900

36. Describe strategies, both implemented and planned, to improve utilization of EPSDT oral health services to ensure increased member participation beginning at age 1 and continuing through age 20.
References: Section D, Paragraph 10, Scope of Services; AMPM, Chapter 400

37. Describe how members are educated on the availability of family planning services and how to access those services. Describe the process to be used to facilitate access to primary care services (a non-covered benefit) by SOBRA Family Planning Extension participants, as well as no- or low-cost family planning services when these members lose eligibility.
References: Section D, Paragraphs 10, Scope of Services, and 32, Referral Management Procedures and Standards; AMPM, Chapter 400; AHCCCS 1115 Waiver, Special Terms and Conditions #39

38. Describe Offeror's participation and/or planned participation in the Arizona Quality Improvement Organization's initiatives such as, but not limited to: diabetes management, hospital quality improvement, and activities/initiatives of other Arizona community organizations.
References: Section D, Paragraph 23, Quality Management (QM); AMPM, Chapters 400 and 900

39. Describe how the Offeror identifies members with Behavioral Health needs.
References: Section D, Paragraph 12, Behavioral Health Services; AMPM, Chapters 400, 500, 900 and 1000

40. Describe the Offeror's process for referring members with behavioral health care needs to the RBHA, and for assisting members in accessing services in the RBHA system.
References: Section D, Paragraph 12, Behavioral Health Services; AMPM, Chapters 400, 500, 900 and 1000

41. Describe the Offeror's process for coordinating care between the RBHA/treating provider and the PCP.
References: Section D, Paragraph 12, Behavioral Health Services; AMPM, Chapters 400, 500, 900 and 1000

42. Describe how PCPs are educated on their ability to treat attention deficit/hyperactivity disorder (ADHD), depression and anxiety behavioral health conditions, and monitors PCPs to ensure appropriate care is provided.
References: Section D, Paragraph 12, Behavioral Health Services; AMPM, Chapters 400, 500, and 900

43. Essay – Describe how the Offeror envisions Medical Homes to be developed and integrated as a service for members with special health care needs and for members with chronic illnesses who would benefit from the assistance a Medical Home would provide. Please include in the description what services would be provided and by what type of staff (provider or health plan), how providers would be involved in and participate in the Medical Home model, and how reimbursement would be modified to appropriately reimburse for a true Medical Home. Consideration should also be given to how outcomes of the Medical Home, including utilization patterns, would be evaluated. (not to exceed 10 pages total)

    - Please include a description of how Offeror will staff/resource this project if selected as the successful Offeror, with additional funding anticipated to be paid until the project is completed as determined by AHCCCS (prorated if less than a complete year).

    - The response submitted for this submission requirement will not be used to consider contract award for the RFP. The response will be evaluated to determine the potential award of additional administrative funds for one to two Offerors awarded contracts in this RFP. The AHCCCS Administration reserves the right to request additional information before making final awards in the development of a Medical Home model program.

    References: Section D Paragraph 75, Pending Legislative/Other Issues; AMPM Chapters 400, 900 and 1000

V. Organization

Organization refers to the Offeror's ability to perform the administrative tasks necessary to support the requirements identified throughout this RFP. The following identifies the submission requirements.

Required Submissions: Organization

Organization Questions

44. Submit resumes of key personnel. Include information on how long the personnel have been in these positions. If personnel are not in place, submit job descriptions outlining the minimum qualifications of the position(s). Each resume or job description is limited to three pages.

References: Section D, Paragraph 16, Staff Requirements and Support Services

45. Submit an organizational chart down to the supervisor level that includes the number of employees under the supervisor for the following functional areas: Member Services, Provider Services, Medical Management, Grievance System, Finance, Claims, Encounters, Information Systems, EPSDT and Quality Management. (no page limit)

    - The chart must identify the functions that have been subcontracted in a Delegated Agreement, Management Service Agreement and or Service Level Agreement.
    - Provide the number of full-time equivalent employees who are or will be devoted to the program by functional area.
    - Provide (in parentheses next to title) the physical location of each functional area.

    References: Section D, Paragraphs 16, Staff Requirements and Support Services, and 37, Subcontracts

46. Describe the Offeror's initial and ongoing employee training program. In addition to the three page submission the Offeror must include a syllabus of the Offeror's initial and ongoing trainings.
    References: Section D, Paragraph 16, Staff Requirements and Support Services

47. Describe the Offeror's experience as a managed care contractor in a publicly funded program and or as a managed care organization in a non-publicly funded program. Include a table showing current Medicare and Medicaid risk contracts and other risk contracts to include date started and enrollees by risk group. In addition, include a table of Medicare and Medicaid contracts discontinued within the past five years (January 1, 2003) and the reason(s) for the termination. (narrative response limited to 3 pages; tables may exceed this limit)

48. Please provide the information listed below for a minimum of three governmental entities with which the Offeror or a related organization (e.g. parent company) holds a managed care risk agreement. If the Offeror does not have three separate contracts with governmental entities, the Offeror must specify this fact and submit the information below for all governmental entities with which it holds a contract.

    - Contact information must include: name of governmental entity, type of contract and relevant contract number(s), contact person, telephone number and address.
    - Submissions must include, and identify, at least one reference (other than Arizona) for an entity with which the Offeror has received a performance sanction (does not have to be monetary). Not applicable if no sanctions have been levied.

49. Describe the Offeror's process to select and monitor subcontracted entities (Delegated Agreement, Management Service Agreement and or Service Level Agreement) providing services in any or all of the following functional areas: health plan Administration, Member Services, Provider Services, Medical Management, Grievance System, Finance, Claims, Encounters, Information Systems, EPSDT and Quality Management. Describe the authority the Offeror's CEO (as identified on the Organization Chart, not the CEO of the subcontractor) has to effectuate change over each subcontracted functional area.
    References: Section D, Paragraph 37, Subcontracting

50. Describe any sanctions levied against the Offeror, its parent corporation or any legally related corporate entity since January 1, 2005 that have been imposed by AHCCCS, Medicaid programs in other states, Medicare or any state insurance regulatory body. Include the description of the sanction, the specific reason for the sanction and the timeline to resolve or correct the deficiency. Sanctions are defined as any monetary and non-monetary punitive actions taken by regulatory bodies. (narrative response limited to 3 pages; tables may exceed this limit)

51. Describe the Offeror's information services organization, and the hardware and software that will support the AHCCCS line of business, including a diagram of the information system and data processing flow with all existing or planned interfaces. If not a current Contractor, the Offeror must include a detailed plan for ensuring that all IS requirements will be met prior to the contract start date. (Submission requirement not to exceed 10 pages, plus flowcharts)
References: Section D, Paragraphs 38, Claims Payment/Health Information System, and 64, Data Exchange Requirements

52. Describe the Offeror's information system change order or software modification processes, the date of the last major version update, and indicate if there is a planned system conversion within the contract period (five years). If yes, indicate which subsystems will be affected and describe the planning and system implementation process.

    System conversion is defined as a significant modification to the managed care system used by the Offeror. Significant modification would include migration from one software product or vendor to another, or a major version upgrade to the product from its current vendor. This would also include any significant changes or enhancements in functionality to the system for enrollment of members, maintenance of member benefits, premium/capitation payment posting, provider contracts, prior authorization of claims, and payment/encounter reporting.

    References: Section D, Paragraphs 38, Claims Payment/Health Information System, and 64, Data Exchange Requirements

53. When was the last IT-specific external operational audit or external performance review of the Offeror's system/division? Provide the contact information for the external organization if applicable.
References: Section D, Paragraphs 38, Claims Payment/Health Information System, and 64, Data Exchange Requirements

54. Describe Offeror's HIPAA version migration plans, ability to support future HIPAA mandates, and the system's ability to support E-health connectivity (i.e., electronic health records)
References: Section D, Paragraphs 38, Claims Payment/Health Information System, and 64, Data Exchange Requirements, and 74, Technology Advancements

55. Indicate how many years the Offeror's IT organization or software vendor has supported the information system, and whether or the not the software version currently operated by the Offeror is supported by the software vendor. If Offeror's software is vendor supported, include vendor name(s), address, contact person and version(s) being used.
References: Section D, Paragraphs 38, Claims Payment/Health Information System, and 64, Data Exchange Requirements

56. Provide a detailed flowchart and narrative description of the claims adjudication process, addressing both paper and electronic claims submissions. Include processing timeliness standards, coordination of benefit activities and how claim inquiries are handled. The submission requirement should not exceed three pages of narrative and an additional three pages of flowcharts.
References: Section D, Paragraphs 38, Claims Payment/Health Information System, and 58, Coordination of Benefits

57. Provide a description of the monitoring process for accurate and timely claim adjudication and how identified deficiencies are resolved.
References: Section D, Paragraph 38, Claims Payment/Health Information System

58. Provide a description of the clinical edits and data related edits included in the claims adjudication process.
References: Section D, Paragraph 38, Claims Payment/Health Information System

59. Describe the Offeror's Corporate Compliance Program.
References: Section D, Paragraph 62, Corporate Compliance

60. Describe the Compliance Officer's level of authority and reporting relationships.
References: Section D, Paragraph 62, Corporate Compliance

61. Submit a description of the Offeror's encounter submissions process including, but not limited to, how accuracy, timeliness and completeness are ensured and the remediation process when AHCCCS standards are not met.
References: Section D, Paragraph 65, Encounter Data Reporting; Encounter Reporting User Manual

62. Describe the Member Grievance process from identification to resolution. Include the communication process with other departments, internal benchmarks for timely resolution and average time of resolution.
References: Section D, Paragraph 26, Grievance System; Attachment H(1); ACOM Enrollee Grievance Policy

63. Describe how the organization monitors the operational effectiveness of the Member Services Department.
References: Section D, Paragraph 25, Administrative Performance Standards

64. Describe the Offeror's member orientation and on-going education regarding how to access benefits.
References: Section D, Paragraphs 8, Mainstreaming of AHCCCS Members, 18, Member Information, 20, Cultural Competency; ACOM 404, Member Information Policy

65. Describe how feedback (disenrollment, complaints, survey results etc.) from members is used to drive changes and/or improvements to the Offeror's operations.
References: Section D, Paragraph 26, Grievance System; Attachments H(1), Enrollee Grievance System Standards and Policy; ACOM, 406 Enrollee Grievance Policy

66. Provide a flowchart and written description of the Offeror's grievance system. At a minimum, the description should include the member grievance and appeal process, and the provider and subcontractor claim dispute process. The submission requirement should not exceed five pages of narrative with a maximum of three pages of flowcharts.
References: Section D, Paragraph 26, Grievance System; Attachments H(1), Enrollee Grievance System Standards and Policy, and H(2), Provider Claim Dispute Standards and Policy

67. Describe how data resulting from the grievance system is used to improve the operational performance of the Offeror.
References: Section D, Paragraph 26, Grievance System; Attachments H(1), Enrollee Grievance System Standards and Policy, and H(2), Provider Claim Dispute Standards and Policy

68. Submit the Offeror's plan for meeting the Performance Bond or Bond Substitute requirement including the type of bond to be posted, source of funding and timeline for meeting the requirement.
References: Section D, Paragraphs 46, Performance Bond or Bond Substitute, and 47, Amount of Performance Bond

69. Submit a plan for meeting the minimum capitalization requirement.
References: Section I, Paragraph 13, Minimum Capitalization Requirements

70. Provide the Offeror's two most recent audited financial statements, including enrollment and member month amounts. Include the parent company's two most recent audited statements as well, if applicable. There is no page limit on this requirement. Current Acute Care Contractors who have met this requirement through deliverable submission do not need to resubmit.

    The Offeror refers to the separate corporation established for the purposes of this contract. If no separate corporation exists, the Offeror should submit audited financial statements for the line of business most like the services provided under this contract. If no other financial information is available, AHCCCS will accept the Offeror's corporate financial statement, with an explanation of why other data is not available.

References: AHCCCS Reporting Guide for Acute Health Care Contractors

71. Provide the organization's most recent quarterly financial statements, including year-to-date information where applicable and including enrollment and member month amounts. There is no page limit on this requirement. Current Acute Care Contractors who have met this requirement through deliverable submission do not need to resubmit.
References: AHCCCS Reporting Guide for Acute Health Care Contractors

72. Submit prospective time period financial forecasts by GSA and statewide totals for the first three years of the contract starting with October 1, 2008, including a balance sheet and a statement of revenues, expenses and changes in equity in at least the level of detail specified for annual audited financial statements as outlined in the *AHCCCS Reporting Guide for Acute Health Care Contractors*. Balance sheet and changes in equity statements should be statewide. Income statements should be by GSA and statewide. Include all assumptions used for the forecasts, including enrollment and member months. There is no page limit to this requirement. For the purposes of this question, "Statewide" should be understood to mean all of the GSAs for which the Offeror is submitting a bid combined.
References: AHCCCS Reporting Guide for Acute Health Care Contractors

73. Submit financial viability calculations for the three-year financial projections.
References: Section D, Paragraph 50, Financial Viability Standards; AHCCCS Reporting Guide for Acute Health Care Contractors

74. Describe the Offeror's process for monitoring the appropriateness of the Total Medical Claims liability including the frequency of internal and external reviews; the individuals or entity that will conduct the review; and the method for necessary adjustments resulting from such reviews.
References: AHCCCS Reporting Guide for Acute Health Care Contractors

75. Describe the Offeror's methodology for recording reinsurance revenue and reinsurance receivables and the process for monitoring the appropriateness of reinsurance revenue and reinsurance receivables. The description should include the frequency of review and adjustment.
References: Section D, Paragraph 57, Reinsurance; AHCCCS Reporting Guide for Acute Health Care Contractors

VI. Other

This submission requirement will not be scored or used to determine contract awards for AHCCCS Acute or KidsCare business pursuant to this request for proposals.

Required Submissions: Other

Other Question

76. As described in Section D, Paragraph 75, KidsShare is a health insurance program being considered in the 2008 Legislative Session. Should the program be enacted, it is currently structured as follows:

    Program Design:
    - A full risk program for children only (under 19 years of age)
    - AHCCCS would set a capitation rate range; Offerors awarded contracts under this RFP will be afforded an opportunity to bid a capitation rate and potentially be offered a KidsShare contract.
    - Benefit would be designed based on an affordable premium

    Eligibility Criteria including but not limited to:
    - Resident of Arizona, citizen of the US, or a legal resident
    - Family income above 200% not to exceed 350% of the Federal Poverty Level

- Parent/guardian employer does not offer insurance, or coverage is not extended to dependents
- Employer sponsored coverage or private commercial coverage is unaffordable for the family, i.e. greater than 10% of the family income or exceeding 150% of the premium(s) for KidsShare.
- Child or family member has preexisting conditions that precludes coverage under commercial coverage.

Eligibility and Enrollment:

- AHCCCS would determine eligibility
- Family would choose a Contractor

Please indicate if Offeror is interested in participating in this program. Identify any additional issues for consideration in the development or design of the program. Response must be limited to one page.

[END OF SECTION I]